GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of Contracting and Procurement
Human Care Services

Date March 21, 2007

Re: District of Columbia Human Care Agreements
Women, Infants, and Children Nutrition Services (WIC)

Prospective Providers:

Human Care Agreements allow the District to identify and pre-qualify a register of potential providers of women, infants, and children nutrition services (WIC) to meet the District's needs.

A completed *Contractor's Qualification Record* (CQR) form(Attachment # 1) including supporting documentation is required to be submitted for consideration to receive a Human Care Agreement. The CQR and supporting documentation must provide the District crucial information to determine the provider's financial and professional responsibility to provide WIC services. Potential providers are directed to page 1, General Instructions, of the CQR for instructions on completing the CQR.

Each potential provider shall complete and submit Section B, lines 0001, 0101,0201,0301, and 0401 of the Human Care Agreement, page 3, to document the provider's proposed service rate to provide the indicated women, infants, and children nutrition services. The District anticipates discussions and negotiations of the provider's proposed prices. Special projects initiatives are determined by allotment from U.S. Department of Agriculture.

All compliance documents listed in Section F of the Human Care Agreement must be completed and submitted on the forms attached.

Each potential provider shall include a Program Description(s) and a work plan (attachment # 2) consistent with the service delivery area(s) identified in Section C of the Human Care Agreement, Sections V and VI of the CQR.

The solicitation package is available for pick-up from the bid counter of the Office of Contracting and Procurement at 441 4th Street, NW, Suite 703 South, Washington, DC 20001. The initial review of the solicitation, will close at **2:00** p.m. local time, on April 20, 2007 for the initial evaluation of qualified Providers. CQR will be accepted on an on going basis until April 20, 2008 and will be evaluated quarterly or on an as needed basis to fulfill the District's needs...

Submissions shall be submitted in an original and four (4) copies, in a sealed envelope conspicuously marked **"Response to Solicitation No. DCHC-2007-H-0010: Women, Infants, and Children Nutrition Services."** Submission must be received at the bid counter at **441 4th Street NW, Suite 703 South, Washington, DC 20001** not later than **2:00** p.m. local time, on **April 20, 2007** for the initial evaluation to be considered for award of a human care agreement. Faxed copies will not be accepted in lieu of a hard copy.

The District and the Department of Health are committed to providing the highest quality of service available and look forward to partnerships with qualified providers that share this vision.

Should you have any questions, please contact Mr. Dwight Hayes, Contract Specialist at (202) 724-5278.

Sincerely,

Rotimi Osunsan, CPPB, CPM
Contracting Officer

Attachments

Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

STATUTORY AND REGULATORY AUTHORITY

The Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award human care agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying contractors for a human care agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, 27 DCMR, the regulations.

GENERAL INSTRUCTIONS

1. *Please read and complete each section of the Human Care Agreement Contractor Qualifications Record form. All information must be completed in the spaces provided, or marked "N/A."*

2. *An original signature must be provided in those sections where a signature is required. Copies or a stamped signature **is not** acceptable.*

3. *Included in the package that will be provided to you will be a copy of the "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts", dated November 2004. Please read this document carefully before you complete the Contractor's Qualifications Record. The "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts," dated March 2007, will be incorporated by reference into each Human Care Agreement that is entered into between a contractor that will provide human care services and the District of Columbia.*

4. *Also included in the package that will be provided to you will be forms required by the Department of Small and Local Business Development. You must complete those forms and return them with your package to make it complete and for you to be considered for a Human Care Agreement. The forms are for:*

   a. *Compliance with Section 5 of Mayor's Order 85-85, "Equal Opportunity Obligations in Contracts" and*
   b. *Compliance with Equal Opportunity for Local, Small and Disadvantaged Business Enterprises Amendment Act of 1998, as amended (D.C. Laws 12-268 and 13-169).*

5. *You may use Section VIII, the "Remarks Section", on page 6, to provide additional information or to expand on information that is provided in response to the request for information.*

6. *Please include and attach all information, documentation, and data as instructed and required.*

7. *In those instances where check boxes are provided, please check only the box or boxes which apply.*

CHECKLIST

☐	Did you include your Taxpayer Identification Number?	☐	Did you attach a copy of your most recent Financial Statement?
☐	Did you attach the information required In Section III, Disclosure Information, on page 2?	☐	Did you attach a copy of all licenses and certifications, including any specialty certifications?
☐	Did you list all personnel critical to the performance of your Organization in Section VI	☐	Are you providing a facility? Then, did you attach a copy of the Certificate of Occupancy for each facility?
☐	Did you attach a Certificate of Incorporation, if applicable?	☐	Did you attach a Certificate of Good Standing, if applicable?
☐	Did you attach a copy of your LSDBE certification, if applicable?	☐	Did you attach or include your salary history, if applicable?

FREQUENTLY ASKED QUESTIONS

Q	Can I fax my application for processing?	**A**	No. Contractor Qualifications Records must contain original, not copied signatures.
Q	Is this form available electronically?	**A**	Yes, the Contractor Qualifications Record (CQR) is available on the Office of Contracting and Procurement website, www.ocp@dc.gov.
Q	Who or what is an Individual?	**A**	The term "individual" means a human person who may be licensed, certified, or otherwise authorized or qualified to perform or provide specific human care services. The individual may be solo practitioner or a part of a group.

Q	Who or what is an Organization?	**A**	The term " organization" means an entity, other than an individual, that is licensed, certified, or otherwise authorized, or qualified, to provide or perform human care services in the normal course of business. The license, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual providers in their own right. Examples may include a corporation, joint venture, clinic, hospital, or partnership.

Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

1. DATE OF FILING / /	2. FILING TYPE: ☐ NEW ☐ UPDATE ☐ CORRECTION ☐ REMOVAL	FOR OCP USE ONLY: *DATE RECEIVED BY OCP:*

SECTION I – GENERAL INFORMATION

1. NAME OF INDIVIDUAL/ ORGANIZATION

a. Name:

b. Title:

c. Physical Street Address:

d. City, State & Zip Code:

e. Office Phone: f. Office Facsimile No:

g. E-Mail:

2. TYPE OF ORGANIZATION *(Please check the appropriate box.)*

☐ **INDIVIDUAL** ☐ **JOINT VENTURE**

☐ **CORPORATION** ☐ **GENERAL PARTNERSHIP**

☐ **SOLE PROPRIETORSHIP** ☐ **LIMITED PARTNERSHIP**

3. STATE OF INCORPORATION *(Please check the appropriate box.)*

☐ **DISTRICT OF COLUMBIA** ☐ **COMMONWEALTH OF VIRGINIA**

☐ **STATE OF MARYLAND** ☐ **STATE OF DELAWARE**

☐ **OTHER:** _____

Date Of: _____

3. IS ORGANIZATION?

☐ FOR PROFIT ☐ NON-PROFIT

5. SOCIAL SEC. / TAXPAYER ID NO:

6. DUNN & Bradstreet No:

7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS?

☐ Small ☐ Local ☐ Disadvantaged ☐ Resident-Owned

☐ Enterprise Zone ☐ Longtime Resident

SECTION II – FINANCIAL RESPONSIBILITY INFORMATION

(Please Provide and Attach a Copy of Your Most Recent Financial Statement.)

1. **Name and Address of Accountant:**	2. Name and Address of Financial Institution:
3. Name and Title of Contact Person:	**4. Name and Title of Contact Person:**
5. Telephone No.: / **6. Fax No.:**	**7. Telephone No.:** / 8. Fax No.:
9. Date Of Attached Financial Statement (Must be Within Last 12 Months):	*10. Do You/Organization Owe Any Outstanding District /Federal Taxes:* District Taxes: ☐ NO ☐ YES - Federal Taxes: ☐ NO ☐ YES

11. MEDICAID – MEDICARE INFORMATION:

a. Are You / Organization a Certified Medicaid Provider? ☐ YES ☐ NO Medicaid Number:_____ Date: _____

b. Are You / Organization a Certified Medicare Provider? ☐ YES ☐ NO Medicare Number:_____ Date: _____

SECTION III – DISCLOSURE INFORMATION

(If yes to any questions below, please explain fully in REMARKS SECTION, or attach a separate statement.)

1.	Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program? ☐ YES ☐ NO
2.	Is your license, or any in the organization currently suspended or restricted in any way? ☐ YES ☐ NO
3.	Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years.: ☐ YES ☐ NO
4.	Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?: ☐ YES ☐ NO
5.	Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?: ☐ YES ☐ NO
6.	Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?: ☐ YES ☐ NO

SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE

1. List All Contracts With the District Government Within the Past Five (5) Years:

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

(Please Use and Attach a Separate Sheet for Additional Items.)

2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years:

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

(Please Use and Attach a Separate Sheet for Additional Items.)

3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	
F					to	

(Please Use and Attach a Separate Sheet for Salary History and Additional Items.)

4. List At Least Five (5) References Familiar With Service Delivery:

	Name	Tittle/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						
E						

(Please Use and Attach a Separate Sheet for Additional Items.)

4. ARE YOU A UNIITED STATES CITIZEN?	5. ARE YOU A PERMANENT RESIDENT? *(Please Attach Documentation To Support))*	6. IF YOU ARE NOT A CITIZEN, CAN YOU PROVIDE AND SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES? *(Please Attach Documentation To Support.)*
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

SECTION V – EDUCATION, CREDENTIALS AND LICENSURE

1. Please List All Colleges (Undergraduate and Graduate) and Professional Institutions Attended:

	Chief Study Subject Area	*Name of College, University or Professional School*	*Address and Zip Code*	*Dates Attended*	*Date And Type Degree Awarded*
A				To	
B				To	
C				To	
D				To	
E				To	

(Please Use and Attach a Separate Sheet for Additional Items.)

2. Please List All Professional Certifications and Licenses (Copies Must Be Attached):

	License/Certification	*Agency/Entity*	*State*	*Number*	*Effective Dates*	*Date Issued*
A					to	
B					to	
C					to	
D					to	
E					to	

(Please Use and Attach a Separate Sheet for Additional Items.)

3. Please List All Speciality, Certifications and Licenses (Copies Must Be Attached):

	Specialty License/Certification	*Agency /Entity*	*State*	*Number*	*Effective Dates*	Date Issued
A					to	
B					to	
C					to	
D					to	

(Please Use and Attach a Separate Sheet for Additional Items.)

4. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED? ☐ YES ☐ NO

(*If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

(Please Use and Attach a Separate Sheet for Additional Items.)

5. Please list any hospital affiliations or privileges below:

	Name of Individuals(s)	*Name of Hospital*	*Address*	*Type Privilege/Affiliation*	*Telephone*	*Fax No.*
A						
B						
C						
D						

(Please Use and Attach a Separate Sheet for Additional Items.)

6. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY HOSPITAL PRIVILEGES REVOKED, FOR ANY REASON? ☐ YES ☐ NO

(*If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

SECTION VI – SERVICE DATA AND INFORMATION

1. GENERAL SERVICE CATEGORIES: Pleas Check Each Of The General Service Categories For Which You Or The Organization Are Applying.

- ☐ Education (EDS)
- ☐ Special Education (SED)
- ☐ Health (HTH)
- ☐ Human Services (HUM)
- ☐ Mental Health (MEN)
- ☐ Psychology (PSY)
- ☐ Social Services (SOC)
- ☐ Youth/Juvenile Justice (JUV)
- ☐ _____

2. POPULATIONS: Pleas Check All That Apply For Populations.

- ☐ Children & Youth (CYG)
- ☐ Children & Youth-Detained (CYD)
- ☐ Children & Youth-Committed (CYC)
- ☐ Children & Youth-Supervision (CYS)
- ☐ Special Education (SED)
- ☐ Adults (ADT)
- ☐ Adult Forensic-Psychiatric (AFP)
- ☐ Adult Forensic-Correctional (FC)
- ☐ Physically Disabled (DIS)
- ☐ Mentally Retarded (MRD)
- ☐ Developmentally Disabled (DVD)
- ☐ Geriatric (GER)
- ☐ Pregnant Women (PGW)
- ☐ Hearing Impaired (HIM)
- ☐ Blind/Visually Impaired (BLD)
- ☐ Homeless (HLS)
- ☐ Multicultural (MLT)
- ☐ HIV/AIDS (HIV)
- ☐ Dually Diagnosed (DUD)
- ☐ _____

3. SETTING CODES: Please Check The Settings Where You Or The Organization Can Or Will Provide Service.
(If You Or The Organization Has A Facility, Then A Certificate of Occupancy Must Be Included and Attached.)

- ☐ Addiction Treatment Facility (ADF)
- ☐ Ambulatory Care/Surg Center (AMB)
- ☐ Child Development Center (CDC)
- ☐ Comm Day Program (CDP)
- ☐ Comm Health Center (CHC)
- ☐ Comm Residential Facility (CRF)
- ☐ Crisis Center (CRC)
- ☐ Foster Care Home (FCH)
- ☐ Detention Facility–Youth (DFY)
- ☐ Detention Facility –Adult (DFA)
- ☐ Dialysis Center (DIA)
- ☐ Group Home –Youth (YGH)
- ☐ Group Home-MR (MGH)
- ☐ Homeless Shelter (HOS)
- ☐ In the Field (FLD)
- ☐ Inpatient-Pychiatric (INP)
- ☐ Inpatient-Medical (INM)
- ☐ Intermed Care Center-MR (IMR)
- ☐ Laboratory (LAB)
- ☐ Nursing Care Facility (NCF)
- ☐ Outpatient Clinic (OTC)
- ☐ Private Home (PRH)
- ☐ Provider' s Office or Facility (POF)
- ☐ School (SCH)
- ☐ _____

4. SPECIFIC SERVICE CATEGORIES: Please Check the Specific Service Categories That Apply To You or The Organization in which you are qualified, including licenses, or certified, to provide services:

- ☐ Addiction Treatment Services (ADT)
- ☐ Allergy (ALG)
- ☐ Addiction Treatment Services (ADT)
- ☐ Assessment/Diagnosis (ASS)
- ☐ Audiology (AUD)
- ☐ Assessment Diagnosis (ASD)
- ☐ Birthing Services (BIR)
- ☐ Case Management-Family Services (CMF)
- ☐ Case Management-Medical (CMM)
- ☐ Case Management-Social (CMS)
- ☐ Child Care Services (DAY)
- ☐ Chore Services (CHR)
- ☐ Consulting (CON)
- ☐ Counseling Services (CSL)
- ☐ Crisis Intervention Services (CRI)
- ☐ Day Treatment Services (Habilitation) (DTR)
- ☐ Dental Services (DEN)
- ☐ Dialysis Services (DIA)
- ☐ Early Childhood Intervention (ECI)
- ☐ EPSDT Screening (EPS)
- ☐ Family Services (FAM)
- ☐ Homemaker Services (HOM)
- ☐ Dental Hygienist (DHY)
- ☐ Laboratory Screening Services (LAB)
- ☐ Mental Health (MEN)
- ☐ Midwiifery (MID)
- ☐ Music Therapy (MTH)
- ☐ Neurology (NEU)
- ☐ Nutrition and Dietary (NUT)
- ☐ Occupational Therapy (OTH)
- ☐ Optometry (OPT)
- ☐ Pediatric (PED)
- ☐ Personal Care Services (PCS)
- ☐ Physical Therapy (PTH)
- ☐ Podiatry (POD)
- ☐ Pre-Natal Services (PNA)
- ☐ Psychological Services (PSC)
- ☐ Pyschiatric (PSY)
- ☐ Recreation Therapy (RTH)
- ☐ Respiratory Care Services (RES)
- ☐ Respite Care (RSC)
- ☐ Supported Employment Services (SES)
- ☐ Social Worker Services (SWS)
- ☐ Speech Therapy (STH)
- ☐ Transportation Services (TRS)
- ☐ Visiting Nurse (home) (VIS)
- ☐ Vocational Rehabilitation (VOC)
- ☐ _____

5. LICENSURE AND CERTIFICATION CATEGORIES: Please Check All of the Licensure and Certification categories that Apply to You or the Organization in which you are qualified, And Are Licensed Or Certified To Provide Services:

- ☐ Acupuncture Therapist (ACC)
- ☐ Advanced Practice Registered Nurse (ARN)
- ☐ Architect (ARC)
- ☐ Audiologist (AUD)
- ☐ Certificate of Occupancy (COO)
- ☐ Child Development (CHD)
- ☐ Dental Hygienist (DHY)
- ☐ Dentist (DEN)
- ☐ Chiropractor (CHP)
- ☐ Foster Care Provider (FOS)
- ☐ Funeral Directors (FUN)
- ☐ Gynecology (GYN)
- ☐ Massage Therapy (MAS)
- ☐ Naturopathy (NAT)
- ☐ Nurse-Anesthetist (RNA)
- ☐ Nurse-Midwife (RNM)
- ☐ Nurse Practitioner (RNP)
- ☐ Nutritionist & Dietician (NUT)
- ☐ Obstetrician (OBS)
- ☐ Occupational Therapist (OTH)
- ☐ Optometrist (OPT)
- ☐ Opthomology (OPG)
- ☐ Pharmacist (PHM)
- ☐ Physical Therapist (PTH)
- ☐ Physician (DOC)
- ☐ Physician Assistant (PAS)
- ☐ Podiatrist (POD)
- ☐ Practical Nursing (LPN)
- ☐ Professional Counseling (PRO)
- ☐ Psychologist (PSC)
- ☐ Pyschiatrist (PSY)
- ☐ Registered Nurse (RNN)
- ☐ Respiratory Care (RES)
- ☐ Social Worker-Clinical (SWC)
- ☐ Social Worker (SWS)
- ☐ _____

6. LANGUAGE SKILLS: Please Check All that Apply for Your Or The Organization' s Language Skills:

- ☐ English (ENG)
- ☐ Spanish (SPN)
- ☐ International/Universal Sign (SGN)
- ☐ Italian (ITL)
- ☐ French (FRN)
- ☐ Haitian Creole (CRE)
- ☐ Vietnamese (VTN)
- ☐ Korean (KOR)
- ☐ Chinese–Cantonese (CCA)
- ☐ Chinese-Mandarin (CMA)
- ☐ Ethiopian (Amharic) (AMH)
- ☐ _____

SECTION VII – PERSONNEL CRITICAL TO ORGANIZATION PERFORMANCE

1. Please list All of the Personnel In your Organization Who Are Critical To organization Performance. Please List Officers, Clinical Directors, Medical Directors, Service Supervisors, and Sub-Contractors Essential to the Performance of Services in this Qualifications Record and Attach Resumes Coded to this Section. Attach Any Copies of Licenses, Certifications, or Credentials Where Applicable.:

	Name	*Title/Position*	*Affiliation*	*Telephone*	*Fax*	*E-Mail*
A						

B						
C						
D						

SECTION VIII – REMARKS SECTION

1. *Please use this section to respond to or to continue to response to any previous question, or request for information. In addition, please feel free to use this section to provide additional information vital to determining your or the organizations qualifications to enter into a Human Care Service Agreement with the District of Columbia*

SECTION IX – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE

1. DRUG-FREE WORKPLACE CERTIFICATION: *Please provide Certification That You Or The Organization Does Or Will Operate In A Drug-Free Manner.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

Name (Please Print)	*Title*	*Signature*	*Date*

(May be signed on behalf of individual or organization.)

2. **STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS:** ***Please provide Certification That You Or The Organization Agree To Be Bound By the Standard Contract Provisions of the District of Columbia.***

I/We, _____ of _____

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts ("Standard Contract Provisions"), dated November 2004, and agree to be bound by all of the provisions, including The requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be Incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

Name (Please Print)	*Title*	*Signature*	*Date*

3. **INFORMATION CONSENT:** ***Please Provide Certification That You Or The Organization Provide Consent To The District To Obtain Additional Information As Needed.***

I/We, _____ of _____

Hereby give, provide and express my consent for representatives of the Office of Contracting and Procurement, Government of the District of Columbia, to

obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Office of Contracting and Procurement. I further understand that the Office of Contracting and Procurement will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

Name (Please Print)	Title	Signature	Date

SECTION XI – TAX CERTIFICATION AFFIDAVIT

1. TAX CERTIFICATION: *Please Provide Certification That You Or The Organization Is In Tax Compliance In the District of Columbia.*

Name of Individual/Organization: _____

Federal Tax Identification or Social Security No.: _____ DUNS No.: _____

Office of Tax and Revenue Registration No.: _____

Unemployment Insurance Account No.: _____

Names and Addresses of Principal Officers of Corporation: 1. _____

2. _____

3. _____

I / We, hereby certify That:

1. I / We have complied with the applicable tax filing and licensing requirements of the District of Columbia.

2. The following information is true and correct concerning tax compliance for the following taxes for the past five (5) years:

		Current	*Not Current*	*Not Applicable*
District:	Sales and Use	☐	☐	☐
	Employer Withholding	☐	☐	☐
	Unemployment Insurance	☐	☐	☐
	Hotel Occupancy	☐	☐	☐
	Corporation Franchise	☐	☐	☐
	Unincorporated Franchise	☐	☐	☐
	Personal Property	☐	☐	☐
	Professional License	☐	☐	☐
	Arena/Public Safety Fee	☐	☐	☐
	Vendor Fee	☐	☐	☐
	Real Property	☐	☐	☐

3. If not current, as checked in paragraph 2, I am / We are in compliance with a payment agreement with the Office of Tax and Revenue, Office of the Chief Financial Officer. *(Please Attach A Copy of the Agreement.)* ☐ YES ☐ NO

4. If no outstanding liabilities exists and no agreement has been made, please attach a listing of all such liabilities. The Office of Tax and Revenue also requires:

   (A) Copies of Form FR 532 (Notice of Registration) or a copy of Form FR-500 (Combined Registration).
   (B) Copies of cancelled checks for the last tax period(s) filed for each tax liability, i.e., Sales and Use, Employer Withholding, etc.)

The Government of the District of Columbia is hereby authorized to verify the above information with appropriate government authorities. The penalty for making false statements is a fine of not more than $1,000.00, imprisonment for not more than one (1) year, or both, as prescribed in D.C. Code, section 22-2514. The penalty for false swearing is a fine of not more than $2,500.00, imprisonment for not more than three (3) years, or both, as prescribed in D.C. Code, section 22-2513.

_____ _____
Signature *Title*

Subscribed and sworn before me on this _____ day of _____, _____.

Notary Public: _____

My Commission Expires on: _____

SEAL

SECTION XII – AFFIDAVIT AS TO ACCURATENESS AND TRUTHFULNESS

I, _____ of being duly sworn on oath, certify that

I am authorized to sign this document and that all of the information contained in this Human Care Agreement Contractor Qualifications Record is complete, true and accurate.

_____ _____

Signature *Title*

Subscribed and sworn before me on this _____ day of _____, _____.

Notary Public: _____

My Commission Expires on: _____

SEAL

Work Plan

The Department of Health, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), requires qualified health and human service Providers to provide nutrition services. Interested Providers should examine the Scope of Services to determine if they can meet the requirements outlined therein. Vendors who desire to perform the services shall submit a Work Plan, **consisting of not more than ten (10) typewritten pages**, describing how they will provide the required services.The Work Plan supplements information contained in the Contractor Qualification Record(CQR), and will be used to evaluate each offeror's capability to perform the services required by the Department.

Instructions for Preparation of Work Plan

In preparing the Work Plan, provide an accurate and complete response to each of the following items, without adding new or different requirements:

Part A. Health Services Operations and Resources of the Agency

1. Briefly describe any unique features or affiliations of the agency which would make it an ideal provider of WIC services.

2. Include Provider financial eligibility guidelines for persons to obtain health services.

   a. Tell what percentage of the persons served are indigent (i.e., on Medicaid or low income).

   b. Indicate whether clients who come to the agency only for WIC services will be charged for any services received.

   If "Yes," please explain.

   c. Indicate if WIC clients be required to register in the agency's Facility.

3. Using the following format, indicate the number of unduplicated persons currently served who are potentially eligible for WIC services.

PATIENT CATEGORY	NEW CLIENTS (AVERAGE/MON)	REVISITS (AVERAGE/MON)
Pregnant women over 18		
Pregnant women less than 18		
Postpartum women (less than 6 months postpartum)		
Infants under 1 year of age		

Children 1 – 5 years		
Deliveries (hospital only)		

4. Indicate which laboratory and anthropometric services are available at the agency:

   a. Indicate how blood work collected by the Provider is analyzed.

   b. If a lab is the source of blood work data, indicate how quickly are results be available.

Part B. Proposed WIC Program Operations

1. **Service Levels.** Indicate the average number of WIC participants the Provider is capable of serving monthly during the base year of the Agreement, and during each of the four option years.

Agreement Year	**Capable Service Monthly Levels**
Base Year	Month One _____ Month Two _____ Month Three _____ Month Four _____ Month Five _____ Month Six _____ Month Seven _____ Month Eight _____ Month Nine _____ Month Ten _____ Month Eleven _____ Month Twelve _____
Option Year 1	Month One _____ Month Two _____ Month Three _____ Month Four _____ Month Five _____ Month Six _____ Month Seven _____ Month Eight _____ Month Nine _____ Month Ten _____ Month Eleven _____ Month Twelve _____

Option Year 2	Month One _____ Month Two _____ Month Three _____ Month Four _____ Month Five _____ Month Six _____ Month Seven _____ Month Eight _____ Month Nine _____ Month Ten _____ Month Eleven _____ Month Twelve _____
Option Year 3	Month One _____ Month Two _____ Month Three _____ Month Four _____ Month Five _____ Month Six _____ Month Seven _____ Month Eight _____ Month Nine _____ Month Ten _____ Month Eleven _____ Month Twelve _____
Option Year 4	Month One _____ Month Two _____ Month Three _____ Month Four _____ Month Five _____ Month Six _____ Month Seven _____ Month Eight _____ Month Nine _____ Month Ten _____ Month Eleven _____ Month Twelve _____

2. **Staffing Pattern.** Attach a functional organizational chart showing the proposed location of WIC organizationally, the lines of supervision, and all WIC positions. Reflect contractors, students, and in-kind staff as full-time equivalents. The recommended and minimum staffing patterns for WIC clinics are based on the service level.

District of Columbia
WIC Program
Minimum and Recommended Staffing Patterns

/

CLOSEOUT PARTICIPATION LEVELS	POSITION DESCRIPTIONS[1]	STAFFING PATTERN Recommended FTE[3]	Minimum FTEs
>7000	Coordinator Asst. Coordinator Nutritionists Health Tech./Clk. Admn./Prog. Asst.	1.0 2.0 7.5 10.0 1.0	1.0 1.0 5.0 7.0 1.0
1100	Coordinator Nutrition Assistant Nutritionist Brstfdg Peer Counselor Health Tech./Clk Brstfdg Peer Counselor	1.0 1.0 1.0 1.0 1.0 0.25	.5 1.0 1.0 1.0 1.0 0.25
1300	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 2.3 1.0 0.25	1.0 2.0 1.0 0.25
1500	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 1.5 2.5 0.3	1.0 1.0 2.5 0.25
1800	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 2.0 3.0 0.4	1.0 1.5 3.0 0.25
2100	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 2.0 4.0 0.4	1.0 1.5 3.5 0.25
2400	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 2.5 4.5 0.5	1 .0 2.0 4.0 0.25
2700	Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 3.0 5.0 0.6	1.0 2.0 5.0 0.25
4900	Coordinator Asst, Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 1.0 5.0 5.0 1.0	1.0 1.0 5.0 5.0 1.0
6000	Coordinator Asst. Coordinator Nutritionists Health Tech./Clk Brstfdg Peer Counselor	1.0 1.0 3.0 5.0 1.25	1.0 1.0 2.0 5.0 1.0
>7000	Coordinator Asst. Coordinator Nutritionists Health Tech./Clk. Admn./Prog. Asst. Nutrition Assistant Brstfdg Peer Counselor	1.0 2.0 7.5 10.0 1.0 1.0 1.5	1.0 1.0 5.0 7.0 1.0 1.0 1.0

2 Agencies with significant non-English speaking participants must hire adequate bilingual staff to meet the needs of its participants.

3 "FTE" means full-time equivalents. The minimum staffing level is based on a participant-to-staff ratio of 350:1. For caseload levels not shown, the minimum staffing pattern should be calculated based on this ratio.

3. **WIC Locations/Facilities.** Using the format shown below, indicate the name and street address of each location at which WIC services would be available, and the number of people to be served at each location. (Add columns to the chart if needed.) Describe the space which will be used to provide WIC services, as follows:

   a. Enter the square footage.

   b. Indicate (by "Yes" or "No") the characteristics of the space designated for WIC at each location.

   Providers responding to this solicitation also have the option of assuming operation of the WIC mobile clinic for provision of direct services and outreach. Interested Providers should include this as part of their response.

4. **WIC Clinic Hours.** For each location, indicate in the chart the hours during which WIC services will be provided (e.g., from 8:30 a.m. to 5:00 p.m. Monday through Friday). Indicate the total number of hours WIC services would be available weekly. Include evening and weekend hours. **DESCRIPTION OF PROPOSED WIC SITES**

Characteristics of the Proposed Site	Location #1	Location #2
Name and address of site		
Ward in which located		
Number of WIC participants to be served		
Proposed hours of operation		

Square footage		
Other specifics (Indicate Yes/No) Has private room (separated by sight and sound) for use in counseling WIC clients		
Has private space for undressing, weighing, and measuring infants and children		
Has room providing partial privacy (either sight or sound) for use in counseling		
Has separate space for group nutrition education (capable of accommodating 10-15 persons)		

If private space for individual counseling, and weighing and measuring children, currently are not available at each location, indicate the Provider's plans (and timetable) for securing such space. Use additional pages if needed.

5. **Outreach and Public Awareness**. Providers presently providing WIC services should briefly describe the outreach or public information activities they would implement to attract clients to the agency's WIC Program.

6 **Start-up Time.** Providers should indicate how soon after the Agreement award would the agency be able to provide WIC services.

ATTACHMENT 3

27 DCMR § 1905.6- PROVIDING THE CRITERIA FOR A DETERMINATION OF RESPONSIBILITY OF POTENTIAL PROVIDER

THE MAYOR OF THE DISTRICT OF COLUMBIA

NOTICE OF FINAL RULEMAKING

The Mayor of the District of Columbia, pursuant to authority granted by section 202(a) of the District of Columbia Procurement Practices Act of 1985, as amended, ("PPA"), effective February 21, 1986 (D.C. Law 6-85; D.C. Code §1-1182.2(a)), hereby gives notice of the adoption of the following final rules, amending Chapter 19 of Title 27 of the District of Columbia Municipal Regulations (Contracts and Procurements). The rules are intended to implement the Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155), effective September 16, 2000.

The rules were originally approved as emergency and proposed rules on October 11, 2000, and a second emergency rulemaking was approved on March 23, 2001. No substantive changes have been made to the text of the proposed rules, as published in the Notice of Emergency and Proposed Rulemaking in the *D.C. Register* on October 20, 2000, at 47 DCR 8590, and as published in the Notice of Emergency Rulemaking in the *D.C. Register* on April 6, 2001, at 48 DCR 3138.

The Council of the District of Columbia approved these rules on June 8, 2001, by Resolution No. 14-85, pursuant to section 205(a) of the Procurement Practices Act (D.C. Code §1-1182.5(a)).

CHAPTER 19

CONTRACTING FOR SERVICES

Subsection 1900.4 is amended to read as follows:

1900.4 A contract may be used to provide services including, but not limited to, the following:

(m) Human care services (in accordance with §§1905 to 1908); and

Sections 1905 through 1908 are amended to read as follows:

1905 HUMAN CARE SERVICES

1905.1 The Director shall, at least annually, determine in writing that the human care procurement method is appropriate for contracts for classes of human care services, for which the quantity, rate of utilization, delivery areas, or specific beneficiaries of the services cannot be accurately estimated at the outset of the procurement process.

1905.2 The contracting officer shall, at least annually, publicly announce all requirements for human care services in accordance with Chapter 13 of this title, and on the Internet site maintained by the Office of Contracting and Procurement.

1905.3 The contracting officer shall give public notice of general requirements for human care services, and issue a request for qualifications on a form prescribed by the Director, inviting interested service providers to respond in writing with a statement of their qualifications to perform the required services.

1905.4 The contracting officer shall use the procedures set forth in §§1905 through 1908 of this chapter to procure human care services rather than the solicitation or source selection procedures specified elsewhere in this title.

1905.5 Compliance with §§1905 through 1908 of this chapter shall constitute a competitive procedure for the procurement of human care services.

1905.6 The contracting officer shall certify the financial and professional responsibility of each potential contractor based on the following criteria:

(a) The type of business or organization and its history;

(b) The resumes and professional qualifications of the business or organization's staff, including relevant professional and/or business licenses, affiliations, and specialties;

(c) Information attesting to financial capability, including financial statements;

(d) Specialized experience and technical competence in the type of work required;

(e) Capacity to accomplish the work in the required time;

(f) A summary of similar contracts awarded to the service provider, and the service provider's performance of those contracts;

(g) A certification of compliance with all applicable tax and filing requirements;

(h) A statement attesting to compliance with wage, hour, workplace safety and other standards of labor law;

(i) A statement attesting to compliance with federal and District equal employment opportunity law;

(j) Information about pending lawsuits or investigations, and judgments, indictments, or convictions against the service provider or its proprietors, partners, directors, officers, or managers; and

(k) Acceptability under other appropriate characteristics of a prospective service provider.

1906 SELECTION OF HUMAN CARE SERVICES PROVIDERS

1906.1 Prior to conducting discussions with a service provider who has submitted a statement of qualifications in accordance with §1905.3, the contracting officer shall make a written determination that the service provider is qualified, based on the criteria in §1905.6.

1906.2 Following pre-qualification of service providers, the contracting officer may:

(a) Conduct discussions with all qualified service providers, and negotiate a price on a unit rate or fee for service basis using benchmarks and quantifiable measurements that are uniformly applied, including but not limited to each service provider's cost data attributable to provision of the services and consideration of each service provider's maximum customer capacity; and

(b) Award a human care agreement to one or more service providers to satisfy all or part of the District's anticipated requirements based on the contracting officer's determination that the contract is in the best interest of the District, considering the service provider's qualifications, its capability of providing the service, and a judgment that the price is reasonable.

1906.3 The contracting officer shall retain statements of qualifications for approved service providers, and consider those providers for award of human care agreements, for a period of three years, following pre-qualification of the providers.

1907 HUMAN CARE AGREEMENT

1907.1 The contracting officer shall include in each human care agreement the following information:

(a) A statement that the human care agreement is not a commitment to purchase any quantity of a particular service covered under the agreement; and

(b) A statement that the District is obligated only to the extent that authorized purchases are made pursuant to the human care agreement.

1907.2 The contracting officer shall issue a task order for required services under each human care agreement, and secure all appropriate approvals and funding prior to execution of the task order.

1907.3 As far as practicable, the contracting officer shall give qualified service providers fair and equal treatment with respect to the issuance of task orders.

1908 VOUCHERS

1908.1 Upon a written determination by the Director approving the use of vouchers for a human care contract, the contracting officer following award of the contract may issue vouchers to eligible customers to use for the purchase of human care services.

Sections 1909 through 1912 are repealed.

Section 1999 is amended to read as follows:

1999 DEFINITIONS

1999.1 When used in this chapter, the following words and terms shall have the meanings ascribed:

Appraisal services – services performed by an expert licensed by a state, city, county, or other governmental unit which are associated with the purchase and lease of real property relating to the determination of the value of real property.

Award information – information regarding the name of the contractor and the amount of the contract award.

Consultant – a firm or individual with knowledge and special abilities not generally available to an agency who renders services of a purely advisory nature relating to governmental functions or agency administration and management.

Consulting services – services of a purely advisory nature relating to governmental functions, agency administration and management, or program management which are normally provided by persons that are considered to have knowledge and special abilities not generally available within the agency.

Customer – a recipient of human care services.

Expert – a person with excellent qualifications and a high degree of attainment in a professional, scientific, technical, or other field, whose knowledge and mastery of the principles, practices, problems, methods, and techniques of his or her field of activity, or of a specialized area in the field, are clearly superior to those usually possessed by ordinarily competent persons in that activity, and whose attainment is such that he or she usually is regarded as an authority or as a practitioner of unusual competence and skill by other persons in the profession, occupation, or activity. An expert may be a person who performs or supervises regular duties and operating functions.

Human care services – education or special education, health, human, or social services, to be provided directly to individuals who are disabled, disadvantaged, displaced, elderly, indigent, mentally ill, physically ill, unemployed, or minors in the custody of the District of Columbia.

Task order – an order for services placed against an established human care agreement.

Pre-qualification – the process by which the contracting officer determines whether a prospective service provider under a human care agreement is responsible.

Voucher – a written authorization, to a service provider who has been awarded a human care agreement, to provide the services authorized in the agreement and described in the voucher directly to an individual identified in writing.